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Written Testimony to the Healthcare Reform Implementation Council

On behalf of our nearly 90 member agencies providing services and supports to children and adults with developmental disabilities and/or mental illness in over 900 locations around Illinois, thank you for the opportunity to comment on areas related to Medicaid reform. The Association is interested in the issue as it will impact every one of our members - both as organizations that deliver clinical care and as organizations that employ direct care staff who earn just above (and sometimes below) the federal poverty level. Many of those employees may become eligible for Medicaid in 2014. It is a sad circumstance but it is a reality in Illinois. We are hoping, however, to look at Medicaid and broader healthcare reforms as opportunities. It is in that context that we provide our input per the Council's request.

Issue #1 - After January 1, 2014, the Affordable Care Act (ACA) will make about 700,000 more Illinoisans eligible for Medicaid by covering all people with incomes less than 133% of the Federal Poverty Level (now about $14,000 for an individual or $30,000 for a family of 4), with 100% federal funding for the first four years. What are the implications of this significant expansion for the Medicaid Program?

First and foremost, IARF will press for an implementation strategy that includes the out years after the federal funding reimbursement of 100% goes away. If there is not a strategy to sustain the program beginning January 1, 2019 we will have made promises to citizens that are vulnerable and we cannot walk away from them when they have begun to build their lives because of our lack of planning.

Further, we recommend that Illinois' plan for healthcare and Medicaid reforms be vetted and decided by the end of January 2013 allowing for a full year of training and implementation and any adjustments that must be made prior to enrollments going live.

Beyond that, there are a number of workforce issues that will be impacted by the implementation of healthcare reforms, including:

- The increased demand for a trained and stable workforce to support approximately 700,000 new enrollees. Individuals with developmental disabilities and mental illness already have difficulty accessing certain types of healthcare services, for example, dental care. The barriers to access are due to a variety of factors, including inadequate rates and the lack of training to address the specific needs to these populations. IARF recommends that a plan be developed now to address the existing barriers to access prior to the influx of new enrollees. (This is documented academically in several studies and plays out every day in community organizations around the state who struggle with recruitment and retention even now before the system is challenged by additional enrollees.)
- Section 5101 of the ACA, creates the National Health Care Workforce Commission to look at the workforce crisis. There are several solutions included in the ACA that could relieve the workforce dilemma, such as full repayment of educational loans in exchange for working in rural areas, the establishment of alternative dental health care providers (Section 5304), the availability of training for direct care workers that are employed in long term care settings (Section 5302), and training grants for Mental and Behavioral Health Education (Section 5306). The Association will continue review the ACA and will provide additional input to DHFS urging incorporation of key items in the discussion. DHFS will be an important liaison to the Commission and we cannot underscore the importance of your advocacy relative to community services workforce issues.

- Direct support workers in community human service organizations may become eligible, themselves, for Medicaid coverage in 2014. The Association's 2010 Salary Survey found that a substantial number of entry level direct support positions, based on average salaries, will be eligible for Medicaid benefits beginning January 1, 2014.
- The disparity of reimbursement for practitioner level professionals in community settings. The Association has worked for years to garner parity reimbursement for Nurse Practitioners who work in community settings. Currently, they are reimbursed under Medicaid if they provide services in a "health care" setting such as a physician's office. However, that is not extended to same license practitioners in community mental health centers and community DD organizations. There needs to be continuity in reimbursement strategies to support practitioners that deliver services in community settings.

- Many of the published reports on system evolution indicate an expansion of internet information exchange. IARF does not believe the State should assume that all of the 700,000 new enrollees will have reliable access to the internet. If the ultimate platform for education and enrollment is electronic, careful consideration must be given to bringing along those who may not have individual access and those who may not have the intellectual capability to navigate such an e-commerce situation. There can be effective solutions to such issues but they must be carefully discussed and agreed upon at the beginning of the conversation not as an afterthought post-implementation.

Within the bounds of the State's fiscal condition, what changes would improve the Medicaid Program?

If the statement "within the bounds" implies that decisions must be made which are fiscally responsible then a couple of key areas are worth noting. If the statement implies a lack of investment of any new dollars then we are direly concerned with the ability of the community system to contribute in a meaningful way to the state's response to healthcare systems reforms and more importantly to the improvement of individuals' health and quality of life.

So, for purposes of this input we will assume is means fiscally responsible investments of new dollars either through federal pass-through or the state's investment of general revenue funding.

- Foremost in our minds is the issue of payment delays. Community organizations have not been part of the protected "class" of Medicaid providers that were guaranteed a 30-day payment cycle with the federal stimulus program. In fact, the prioritization of those three provider groups has negatively impacted the stability of Illinois' other Medicaid providers through extending the payment delays for community mental health and DD organizations while the state struggled to meet the requirement. Further, Illinois is one of only a few states that do not pay <u>all</u> Medicaid providers within 30 days of services being rendered. Clearly, the state recognizes the problems that are created for its vendors but payment delays must be addressed now and certainly as part of expansion of the program in January of 2014.
- Secondly, as safety net providers, Illinois' community agencies serve a disproportionate number of individuals on Medicaid. (Over the past two years grant funding has either been converted to fee-for-service or eliminated for those individuals that do not meet the financial or clinical eligibility requirements of Medicaid.) Unlike hospitals, there is no disproportionate share designation for community agencies that serve mostly individuals on Medicaid. As such the Medicaid rates are especially critical to agencies' ability to adequately serve individuals. There have been numerous studies in Illinois that verify that the rates currently paid to community organizations are woefully inadequate. These studies suggest that the rates are anywhere from 20 – 25% below the cost of providing the services. This translates into management strategies that hold positions open, suppress wages and benefits for workers, and limit ancillary services that are essential to full integration into the community. Inadequate rates also impact access to healthcare services. Illinois has swept the issue under the rug for many years. It cannot be ignored any longer. We suggest the Revenue Commission be immediately seated and complete its work in the next twelve months to look at how community services are funded, identifying the gaps, and developing a plan to fund the gaps and shortfalls in rates by the January 2014 implementation of these reforms.

- Thirdly, coordination of policy and budgeting processes among state agencies that provide services and supports to individuals enrolled in Medicaid needs to be strengthened. The growing demand for increased efficiency needs to begin from the top down with a self examination amongst state agencies that serve individuals on Medicaid to assess the level of duplication in regulations, survey processes, and reporting requirements. Additionally, many individuals enrolled in Medicaid have multiple needs that do not fit exactly into the numerous state departments and divisions within state agencies. For example, individuals that are dually diagnosed with a mental illness and substance abuse issues and individuals with developmental disability and a mental illness would benefit from a coordinated approach to service delivery. It is time to remove the existing "silos" here in Illinois and focus on the provision of quality service delivery.
- There are numerous federal grant opportunities to assist states in preparing for the implementation of the ACA. IARF recommends that Illinois not miss the opportunities afforded by those planning grants and immediately create a process within the Department to ensure that Illinois is responding to these federal funding opportunities in a coordinated and timely manner.

Issue #2 - These low-income individuals and families will likely move, from one year to the next, between public coverage through Medicaid and private health insurance supported with tax subsidies through Health Insurance Exchanges. How should we ensure continuity of health care -- in benefit coverage and in provider networks?

- Presumed eligibility has been successfully used in health care settings in Illinois for many years yet in community services – particularly community mental health services – it has not been incorporated into the service strategy. As a result, the known situation of individuals moving in and out of the system of service creates significant hardship for the individual and the provider of service. Cumbersome re-application and authorizations cause mountains of paperwork and additional risks to providers who clinically and ethically provide the service but are unsure if the state will reimburse for the services. Presumed eligibility must be a part of healthcare system reforms to ensure seamless transitions between public and private coverage.

- Service applications/renewals/authorizations remain problematic for disability and mental health providers and should be resolved during these discussions.
    - For individuals with intellectual/developmental disabilities the process can take months for the authorization for services to be approved. The paper process of application and review needs to be updated to an electronic format that allows fewer input errors and more timely submission and status updates.
    - For individuals with serious/persistent mental illness the process has been electronic since the incorporation of the Administrative Services Organization (ASO) in 2007. While the ASO has been in place for a few years, there are still problems with the application and authorization processes.

  In anticipation of the 2014 influx of new participants and the ongoing coordination of care for individuals currently receiving services these processes require our attention.

- Electronic records, and the lure of federal funding that goes along with health care reform, are ripe for inclusion in system reform discussions. Most community mental health centers have already invested (with their own resources) in electronic formats. They did so to comply with the state's transition to fee-for-service. The upside of that situation is that many are already using electronic recording of case notes, billing codes, etc. The downside of the situation is that many are unique only to the organization. The Association is a strong advocate for electronic records and understands that systems must talk to one another if we are to improve care coordination, see efficiencies of resources and the other benefits of the format. Community organizations must be at the table as Illinois prepares for integration of data and information. This input is critically important from both the mental health and the developmental disability constituencies and the Department of Healthcare and Family Services and the Department of Human Services must be fully aware of the current capacity and gaps

that exist. Development of electronic record requirements and data exchanges cannot occur outside of the inclusion of all Medicaid providers. Linking data systems will be a huge challenge for Illinois and all components of designing affordable care systems must be taken into consideration.

Another key component to successfully linking data systems is the training of staff to fully implement electronic records into their practice. It would be unwise and unfortunate to assume that because most practitioners are familiar with computers they will easily transition to electronic record formats. In consideration of this issue, the Association plans to look at peer-to-peer learning in the coming months. The Department would be shrewd to invest dollars in reimbursing for such training that meets your requirements for compliance with system re-design and implementation.

- Provider certification must be consistent among all departments and divisions for services rendered as part of the ACA. Currently, there are a multitude of disparate requirements between hospital/medical providers and community service organizations. That disparity puts community organizations at a distinct disadvantage in provision of health care and Medicaid services. We note here that efforts are currently underway to implement the requirements of HB 5124/P.A. 96-1141 – a law that requires review of redundancies and duplication of licensures and certifications requirements. The Council would be wise to consider the report that will be issued in January 2011 and incorporate the recommendations into reform discussions.

- Illinois must be mindful that the ACA allows states to include both bare-bones and more extensive insurance options (bronze, silver, gold, platinum). It should be noted, however, that mental health and substance abuse services <u>are required</u> in even the lowest tiered option. IARF encourages DHFS to convene discussions immediately with DHS and key stakeholders regarding benefit design for newly eligible individuals.

The Association is also interested in whether the state expects to pass any legislation to enact the exchange. We are currently reviewing model legislation that has been offered by the National Association of Insurance Commissioners and will be prepared for discussions of its relevance to community disability and mental health services. We strongly advise a discussion about your intentions regarding such legislation and the process for stakeholders input prior to introduction of any such measure.

Issue #3 - The ACA focuses on care management as a central theme of healthcare reform, with the goal of bringing together primary care physicians, specialists, hospitals, long-term care and social service providers to organize care around the needs of the patient to achieve improvements in health. How should the State incorporate the integration of medical services into Medicaid?

- Illinois is currently implementing an Integrated Care Pilot Program where 40,000 individuals in the pilot area will be the beneficiaries of improved coordination of care as one of the primary outcomes. IARF has been very vocal about the need to have an inclusionary planning process that involves stakeholders from the outset. Initially, the process was a bit rocky but we are working together via a stakeholder process to ensure the positive outcomes as outlined in the Request for Proposals can be realized and important lessons can be learned as a result of the pilot. The individuals that are targeted for the pilot include the most vulnerable in our state. It is imperative that an independent evaluation process be undertaken to assess whether the outcome measures as defined in the contract are being met and that individuals are indeed receiving improved health outcomes as a result of the implementation of the integrated care pilot. One of the goals of the pilot is to reduce more costly forms of healthcare, i.e. in-patient hospitalization and emergency room visits. IARF recommends that HFS ensure the two MCO's have an adequate network of providers - including specialists - that are willing to serve the AABD populations prior to enrollment, even if that means delaying the initiation of the pilot.

- Coordination of care will need to take into consideration the unique service needs of individuals with developmental disabilities and mental illness. Transportation to/from medical appointments, supportive housing services for individuals with mental illness, and community-based crisis supports are examples of these unique service needs.

- There is no "one size fits all" approach to improving health and health care for persons with behavioral health needs; the appropriate model will depend on patient needs, onsite capacity, funding environment and community resources. For instance, one of the things behavioral health practitioners will tell you is that a person with a serious/persistent mental illness will not travel to multiple sites for services. So, unless the system is designed with co-location of services in mind it very likely will alienate this population who without consistent supports will continue to access the most costly level of care. Perhaps the much discussed FBQHC model should be an option. At a minimum, the Department must provide incentives for FQHC's and community providers to work together to ensure the best method of an efficient care coordination model is adopted.

Issue #4 - The ACA emphasizes home and community-based services to reduce the reliance on institutionalization for seniors and persons with special needs and offers new state-plan options for states to cover these services. What changes should be made in Illinois' long term care service system (both institutional and community-based) to improve the quality of care and achieve the most cost-effective delivery of appropriate care to achieve the best outcomes for these complex cases?

- Section 10202 of the ACA provides states with new balancing incentives payments. Illinois would be required to make structural reforms to increase diversion from institutions and expand the number of people receiving HCBS – a temporary FMAP increase is available from October 2011 through September 2015.

- One overarching concern with reforms that are being discussed is the tendency to design systems to the "middle." By that, we mean that often in an attempt to meet the needs of the majority of service recipients, the system becomes very standardized and rigid. While we are fully aware of the need to be transparent and accountable, reform discussions must be sensitive to the difference between a medical model and a developmental model. For instance, nursing homes are a medical model following the treatment of illness and/or injury whereas community services for persons with intellectual/developmental disabilities are a developmental or community model focusing on maximizing the potential of the individual. Reform must be careful to understand those nuances and not blindly transfer inappropriate rules/regulations that don't reflect the difference.

- IARF has never advocated for the absolute closure of all institutions. The reason is that we believe it could be short-sighted not to have a safe setting for individuals who may not be able to live in the community. It is a point of great debate we understand but as we have been thinking through a system of our design we continually consider the importance of transitional settings that can stabilize and support persons with that level of need.

- We also believe that the state must consider the creation of crisis group homes available for short term stabilization of health/behavioral circumstances. Without such settings, individuals in community settings all become vulnerable as a result of the lack of options to address occurrences of instability.

- For years, the Division of Mental Health and providers who contract with them have talked about the lack of community residential capacity to support individuals who without that option are at increased risk. Additionally, most in the profession have seen the train coming as advocates and the court systems align to reverse the placement of individuals unnecessarily in institutions. It is essential that Illinois look to the community and work with them to ensure resources are available for residential supports and the wrap around services that are essential to maximize the investment in their living arrangements.

- Section 2401 includes a new state plan option – the Community First Choice Option, which provides for comprehensive home and community-based attendant services and supports for individuals who are eligible for an institutional level of care.

- The ACA, Section 2403, extends the Money Follows the Person Rebalancing Demonstration program through 2016 and allows states to cover people who are institutionalized for over 90 days.

Issues for consideration not specified in the four questions.
In addition to the items outlined above in response to your specific questions, there are a number of other items that bear inclusion in our comments. Each of them deserve and require consideration as Illinois responds to the challenge of Medicaid and broader healthcare system reforms. We have not belabored the items in this document but wanted the Council to be fully informed of our interest and concern about doing this right.

- The ACA provides $25 million to look at Medical Home Models. In previous meetings with the Department of Healthcare and Family Services we have identified several collaborative approaches that have been developed in communities throughout the state. All of these options should be considered and the Association is happy to facilitate the presentation and the outcomes for review.

- The "systems" of service, support and care have operated disparately for so long that legacy programs are entrenched in silos inside the various departments. We are unaware of efforts to coordinate or integrate those systems. For instance, Mental Health billings currently submitted through the Collaborative (DMH Administrative Services Organization) will be required to be submitted to DHFS on July 1, 2011. We recommend this issue of legacy systems be addressed in a timely way so as to avoid problems down the road.

- Section 1302 of the ACA requires all health plans in HIE to offer essential benefits including "rehabilitative, habilitative, mental health and addiction." Such vernacular is open to many interpretations if you consider descriptors of service/program categories in federal definitions, state statute and regulations. A clear understanding is imperative.

- Section 5604 allows for co-location of primary and mental health services in community mental health settings. We see great potential here to improve health outcomes for persons with serious/persistent mental illness. Exploring the opportunity as part of system reform may lead the way to greater coordination of care and individuals with mental illness. The Association is ready to explore such options as part of Illinois' re-design efforts.

Again, we appreciate the opportunity to make our points and offer our assistance in this process. Seeking input and giving that careful and respectful consideration will go a long way in reaching consensus that moves us toward our mutual goal of improving health care for all who are affected in these reforms. Finally, we encourage the Council to equally hear all voices that are part of delivering care and support and to especially consider the voice of the individuals whose lives can be improved as a result of these efforts.

If you have any questions, please do not hesitate to contact us.